EVALUATION OF THE IMPLEMENTATION OF THE RESCUE ME CPR TRAINING PROGRAM

Strategic Management of Change

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ABSTRACT

The Arlington County Fire Department (ACFD) recently embarked on a new method for providing cardiopulmonary resuscitation (CPR) training to its citizens. This new program, Rescue Me, used a video-based, self-instruction methodology that allows participants to learn at their own pace and in their own homes. A change management plan was not formally applied to the inception of this program.

The goal of this research project was to compare the methods employed in developing and implementing the Rescue Me program with those suggested by the Change Management Model from the National Fire Academy's (NFA) *Strategic Management of Change* course. The purpose of the comparison was to identify potential problems that could hinder institutionalizing the program. Historical research determined; (a) the steps taken to initiate and implement the Rescue Me program, (b) if any of the steps taken to implement the program followed the NFA's Change Management Model, and (c) if any elements of the NFA's Change Management Model were missed, could they inhibit the Rescue Me program from becoming institutionalized within the ACFD.

Principal research procedures included: (a) a review of literature written on the topics of CPR instruction for the general public and (b) an analysis of the implementation plan for the Rescue Me program.

The literature supported the wide spread instruction of the general public in CPR and the video based; self-paced method employed by the Rescue Me program. Analyses of the implementation plan for the program showed the implementation team generally followed the task order found in the first three phases of the NFA's Change Management

Model. The analyses also showed however, that significant portions of the fourth phase of the Change Management Model were not followed. These missed portions could contribute to the program not being institutionalized within the ACFD.

Project recommendations include: (a) revision of the overall project goal adopted for the Rescue Me program to one that is more explicit, precise and quantifiable, (b) comparison of the CPR skills from a representative sample of persons trained through the Rescue Me program and persons trained in a traditional method, and (c) publication of the long-term results of the Rescue Me program, whether it succeeds or not.

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INTRODUCTION

The Arlington County Fire Department (ACFD) has been a provider of emergency medical services since its inception in 1949 (Shelton, 1961). In 1971, the ACFD trained its first Emergency Medical Technicians (EMT) and in 1972 these EMTs were trained and certified as advanced life support providers. As part of its mission to provide quality service, the ACFD has made many attempts at increasing the number of lay persons trained in cardiopulmonary resuscitation (CPR). In 1998, the ACFD embarked on a new method for providing CPR training to its citizens. This new program, Rescue Me, uses a video-based, self-instruction methodology to allow participants to learn at their own pace and in their own homes. A change management plan was not formally applied to the implementation of this program.

The goal of this research project was to compare the methods employed in developing and implementing the Rescue Me program with the Change Management Model from the National Fire Academy's (NFA) *Strategic Management of Change* course. The purpose of the comparison was to identify potential problems that could hinder institutionalizing the program. Historical research methods were used to answer the following questions:

1. What were the steps taken to initiate and implement the Rescue Me program in the ACFD?
2. Did the steps taken to implement the Rescue Me program follow the NFA's Change Management Model?

3. Were any elements of the NFA's Change Management Model missed that could inhibit the Rescue Me program from becoming institutionalized within the ACFD?

BACKGROUND AND SIGNIFICANCE

The Arlington County, Virginia Fire Department (ACFD) serves the County of Arlington and the City of Falls Church, Virginia. These localities are densely urban municipalities bordering on the District of Columbia in the northern region of Virginia. The department membership consists of 268 personnel operating from ten stations and providing the following services: fire suppression, emergency medical (including transport), technical rescue, hazardous materials, code enforcement, and fire safety education. The department has been viewed in many circles as a 'state-of-the-art' progressive department.

The ACFD has been a provider of emergency medical services since its inception in 1949 (Shelton, 1961). In 1971, the ACFD trained its first Emergency Medical Technicians (EMT) and in 1972 these EMTs were trained and certified as advanced life support providers. As part of its mission to provide quality service, the ACFD has made many attempts at increasing the number of lay persons trained in cardiopulmonary resuscitation (CPR). As early as 1974, members of the ACFD trained as CPR Instructors were giving demonstrations and classes to the lay public. This activity followed the recommendations of the 1973 Second National Conference on CPR and emergency cardiac care (ECC) to extend CPR training programs to the general public (Emergency Cardiac Care Committee and Subcommittees, American Heart Association [ECCC, AHA], 1974).

In 1984, the ACFD began a formal Citizen CPR Program targeted at the civic associations within Arlington County. This program was intended to address the results of a survey conducted by the Northern Virginia Regional EMS Council (NVREMSC) regarding CPR knowledge and training on the part of the general public. This study surveyed 400 residents of Arlington County and found that 63% had no exposure to CPR training. Additionally, the survey reported that the two principle reasons why citizens had elected not to participate in CPR training were (a) they themselves would not need CPR training (they could not anticipate a need to personally provide CPR), and (b) CPR, as a skill, was too difficult to learn. The ACFD Citizen CPR Program however, met with little success, with only three associations requesting and receiving CPR training (Arlington County Emergency Medical Services Council [ACEMSC], 1986, p. 28).

The ACEMSC presented a Master Plan for Emergency Medical Services for Arlington County, Virginia to the Arlington County Board in November 1986. This plan recommended, among other things, continuation of the Citizen CPR Program to fill the need identified by the NVREMSC survey (ACEMSC, 1986, p. 28). This program was expanded to provide no-cost CPR instruction to the general public in 1989 (Arlington County, Virginia, 1989, February). During the economic downturn of the early 1990s, the ACFD eliminated fiscal support for the Citizen CPR Program in a cost-saving measure, leaving other private and non-profit entities as the only groups offering CPR instruction to the citizenry of Arlington (Arlington County, Virginia, 1991, April).

In 1998, the ACFD embarked on a new method for providing CPR training to its citizens. This new program, Rescue Me, incorporated a video-based, self-instruction methodology to allow participants to learn at their own pace and in their own homes and

at no cost. This program was funded through a partnership between the ACFD, the Arlington Professional Firefighters and Paramedics Association, Local 2800 of the International Association of Firefighters (APFPA), and the Arlington County Department of Libraries (ACDL). Rescue Me, because it represented a significant change in the way the curriculum is presented, the way it is funded and the way it is managed, represented a significant organizational change for the ACFD. The National Fire Academy's (NFA) *Strategic Management of Change* course recommends changes of this magnitude utilize a systematic approach to change management (National Fire Academy [NFA], 1996, 2-3). The Change Management Model, found in Appendix C, of the *Strategic Management of Change* course manual, was used as the standard process against which the implementation of the Rescue Me program was compared. The result of this comparison identified areas of vulnerability where the implementation of the Rescue Me program may have difficulty in becoming institutionalized within the ACFD.

LITERATURE REVIEW

History of CPR Training for the Public

The American Heart Association (AHA) and the National Academy of Sciences-National Research Council cosponsored a national conference on CPR and ECC, the second of its type since the development of CPR, in 1973. This conference made the original recommendation that training in CPR and ECC be extended beyond healthcare professionals to the general public. Additionally, this recommendation included:

(1) CPR training be in accordance with AHA standards,

(2) early warning signs of a heart attack and access to the emergency medical services system be included in ECC, and

(3) The entire population should have access to effective CPR and ECC (ECCC, AHA; 1974; pp. 833-868).

The Third National Conference was held in 1979 and it, among other things, renewed a strong emphasis on the lay communities' responsibility in cardiac care in both the prevention of cardiac related disease and in the role of providing bystander CPR (ECCC, AHA; 1980; pp. 453-509).

In 1985, Durnbaugh commented on the initial 17 years of CPR training. He noted, during that time CPR had gone from a 'physician only' procedure to one that should be learned by every citizen from junior high school age upwards. He further recommended the AHA re-evaluate their assumptions regarding the CPR instructions in-force at that time because, as he stated these assumptions may inhibit the rapid dissemination of CPR. The AHA assumed that:

(1) Effective CPR could only be achieved through strict adherence to a sequential, non-deviating protocol.

(2) The skills necessary for effective performance could degrade without use or re-training and therefore annual re-training was necessary.

(3) Great harm could be done to the victim if the exact CPR technique was not employed.

Durnbaugh then set out to challenge these assumptions one-by-one, advocating a change in direction for lay CPR instruction, given the goal of universal knowledge and ability of the general public to perform CPR. (pp. 64-66)

Scarano, also in 1985, substantiated one challenge by Durnbaugh by reporting, "provided a 1.5 minute, adequately worded telephone instruction to 203 previously

untrained lay persons, the latter's CPR performance on manikins was believed to be comparable to that of formally trained persons" (p. 52). Sherman and McCandless (1986) further illustrated problems identified by Durnbaugh in their survey of 2,028 Northern Virginia residents. CPR instruction, while viewed as important had actually been received by only 10% of those surveyed. Of the 90% who had not received CPR training, one reason sited for not taking CPR instruction was that it took too much time to learn. (p. 107)

The first twenty-five years of CPR practice concluded with it being touted as "the most successful public health initiative since the polio vaccine" (Page, 1985). Newman (1986) concluded from retrospective studies of this twenty-five year period, that CPR's effectiveness was due, in part, to being initiated rapidly after onset of cardiac arrest (p. 52). Newman was also to be one of the first writers to link effective CPR to effectiveness of early defibrillation. She states, "The primary value of CPR within the emergency cardiac care system is its ability to buy time…until advanced life support (defibrillation) becomes available." (p.51).

The proceedings of the Fourth National Conference on CPR and ECC (ECCC, AHA; 1986), among its recommendations included (a) targeted CPR training efforts, (b) emphasized the importance of early defibrillation and, (c) changes to sequencing of the CPR protocol. These changes, especially the sequencing changes, would make the protocol more teachable to the general public, easier to remember (enhance skill retention), and make it easier for multiple bystanders to assist a single victim. Moreover, it was hoped that with a more teachable, easier product, greater numbers of the public

would become trained in CPR and also, in so doing, receive information on heart attack risk reduction. (pp. 2906-2909)

Newman reported in 1988 on a fifth conference on citizen CPR. This conference was now co-sponsored by the AHA, the American Red Cross and the Canadian Heart Foundation. Newman quotes John Paraskos, MD, then chairman of the AHA ECC Committee, "Keeping the patient alive until a defibrillator arrives depends on the availability of witnesses trained and willing to perform CPR." (p.30). More importantly, this conference was the first forum to openly discuss alternate methods of instruction so as to increase the numbers of those trained and willing CPR performers (p.32).

Eisenberg, Horwood, Cummins, Reynolds-Haertle, and Hearne (1990), in their study of the effectiveness of five types of emergency medical service (EMS) systems further emphasizes the role of bystander CPR. They reported that one major determinant of EMS system effectiveness is the general prevalence of bystander CPR within their service area, which then correlates to earlier initiation of CPR, leading to more viable patients and increasing the system's survival rate. Additionally, high rates of bystander CPR can occur as a result of widespread CPR training or as a result of dispatcher-assisted telephone CPR programs. Their findings were substantiated by the research of Spaite et al. (1990) where they demonstrated a significant improvement in cardiac arrest survival with bystander CPR (20%) compared with no-bystander CPR (9.2%) in a retrospective analysis of 298 cases (p. 1264). These findings were again replicated by Swor et al. (1995) where they concluded that patients who receive bystander CPR are more often found by the EMS responders in treatable cardiac rhythms (ventricular tachycardia and

ventricular fibrillation) and they have an increased rate of survival and discharge from hospital. (p. 780)

Newman (1997) reported the biggest benefit by having the general public trained in CPR is not in the technique of CPR itself (although it is still important), but rather having more people aware of the signs and symptoms of cardiac problems which may lead to cardiac arrest. Early recognition also teaches the public, when someone has collapsed and does not respond, to obtain help immediately (p. 49). "This means educating the public about the classic signs of a heart attack: pressure; fullness; squeezing; pain in the center of the chest…" (p.55). Newman concluded that CPR public education, in order to have a more profound impact on public health, needed to once again redefine its message. That message being an equal emphasis on education as well as the technique of CPR. (p. 55)

Alternate Instructional Methods for CPR

The history of CPR instruction has shown a trend toward increasing the numbers of trained citizens willing and able to perform when a cardiac arrest is witnessed (viz., Durnbaugh, 1985; Newman, 1986; Sherman & McCandless, 1986; Newman, 1988; Eisenberg et al., 1990; Newman, 1998). Training methods to be utilized to accomplish this goal began to be offered when the AHA placed greater emphasis on providing training to the general public. (viz.; ECCC, AHA; 1986) Durnbaugh reported in 1985 that, "There are reports…of experimental and modified teaching techniques that seem to lead to more rapid learning, or longer memory retention, or less psycho-motor skill decay, or various combinations of these factors, …and self-instruction methods which yield greater retention than the 'standard' teaching approach." (p. 65).

Sherman and McCandless' (1986) survey attempted to find out if class location could be eliminated as a reason for failure to take CPR training. They provided a list of choices to respondents and schools, local fire rescue stations and places of employment were rated highest. It should be noted that personal or home-based training was not offered among the options. (p. 107)

Newman (1988) quoted William Montgomery, MD, co-chairman of the 1988 Conference on Citizen CPR, "We should be open-minded and welcome innovations such as computer-assisted education, the use of mass media instruction, self-training and dispatcher-assisted telephone CPR. Alternative methods of teaching need to be pursued." (p. 32). Additionally, she recommended that instruction should focus on building student confidence rather than perfect performance so that cardiac arrest victims will not lie unattended while trained rescuers stand immobile for fear of making a mistake (p. 32).

Leary (1988) followed the AHA lead and wrote an article in the journal *Occupational Health and Safety* that condensed the CPR protocol for the purpose of instructing readers in CPR. "The more people instructed in early intervention methods such as CPR, the better the chance of recovery for a victim." (p. 24). Leary prefaced the actual instructions with a recommendation that interested readers obtain actual formal instruction but then provided step-by-step directions for providing CPR. (pp. 24-25)

Newman in her 1990 article on CPR trends for the 1990s, points out that citizens are not medical professionals and should not be treated as such especially when it comes to CPR training. She advocates simplified training regimes as well as teaching the affective side of CPR, addressing feelings, values and attitudes. Students must know that imperfect CPR is superior to no CPR and that any help they give a victim of a cardiac

arrest victim will be beneficial. This addition of affective training is thought to reduce the student's apprehension at performing CPR when needed and also to build the student's personal confidence. (pp. 51-53)

Poliafico (1991), a CPR educator and advocate for widespread CPR education, developed 'Seven Cs' of emergency medical training for students in a wide variety of occupational and cultural settings. Those 'Cs' are capabilities, content, context, comfort, communications, credentials and confidence. The 'capabilities' aspect of CPR training is the actual technique of CPR. The 'content' addresses the completeness of the information, to include preventative measures and how the technique of CPR works. The 'context' portion addresses the questions, "Why and when do we perform CPR?" Regarding 'comfort', Poliafico recommends against conducting CPR training for the general public in classrooms because of an intimidation factor. He states, "Ideally, CPR training should be conducted in homes for small family groups or in a non-chaotic work environment for co-workers". He recommends against issuing 'credentials' (the fifth C) to students who do not require a certificate under a professional regulation. 'Confidence' (the sixth C) comes from the ability to practice at one's own pace. Additionally, he states that videotapes and audio-visuals can be a major adjunct to medical training of citizens, provided it not be totally video based, neglecting the tactile skills which are an integral part of CPR. (pp. 48-61)

Eisenberg et al. (1995) examined a videotape only method for providing bystander CPR training. In their study, 10-minute videotapes were mass-mailed to 8,659 households and those households, along with an additional 8,659 that did not receive a videotape, were studied for three years. Any case of cardiac arrest occurring at a study

household was queried about bystander CPR. No empirical difference was seen between either group for the sixty-five actual CPR incidents occurring during the study. The study concluded that mass mailing of CPR instructional videos is likely to be an ineffective method to increase the rate of bystander CPR (pp. 198-199). However, in the discussion portion of the study, the investigators could not conclude that the videotape had no benefit. They stated that, for a motivated segment of society willing to seek out the videotape, video training might be effective (p. 201).

Summary

It is clear from the literature that since the inception of CPR training for the general public with the national conference in 1973, that the inclusion of trained, willing and able lay rescuers is helpful in sustaining a victim of cardiac arrest until advanced life support care is provided (ECCC, AHA; 1974; ECCC, AHA; 1980; ECCC, AHA; 1986). These assertions were further attested by Eisenberg et al. (1990). Additionally, no source was found that disputed the assertion that CPR was beneficial, nor was one found that did not advocate for greater numbers of trained and willing CPR providers.

Alternative citizen CPR training methods have been found in the literature since 1985 (Durnbaugh, 1985). Sherman and McCandless (1986) brushed upon this issue by asking questions about class location. Montgomery (viz. Newman, 1988) welcomed innovation in methodology, mentioning use of mass media and self-training among others. Poliafico (1991) recommended home instruction as an option for small family groups and he mentioned use of videotaped instruction coupled with tactile instruction with manikins. Lastly, Eisenberg et al. (1995) did not rule out the use of videotaped

instruction as they found some merit for its use in their study, especially for those who take the initiative in finding CPR training.

The trends found in the literature support the effort at home-based, self-instruction using videotapes and manikins that is the central method of the Rescue Me program. Those trends being: use of innovative, self-instruction methodology; self-paced instruction; video as well as tactile skill training; instruction in the signs and symptoms of heart attack and actions to be taken, and; no requirement for certification testing.

PROCEDURES

Research Methodology

The goal of this research project was to compare the methods employed in developing and initiating the Rescue Me program with the Change Management Model from the National Fire Academy's (NFA) *Strategic Management of Change* (1996) course for the purpose of finding potential problems institutionalizing the program (pp. C1-C14). Historical research procedures were used, in that a literature review was conducted, to determine the context and history of CPR training for the general public and approaches used in that training. Additionally, the documentation associated with the Rescue Me program was analyzed against the systematic tasks of the Change Management Model to answer the Research Questions. A copy of the Change Management Model appears in Appendix A. Lastly, incongruities between the recommendations outlined in the Change Management Model and those employed by those initiating the Rescue Me program were noted as these could be problematic to

institutionalizing this program. The memorandum requesting the ACFD implement the Rescue Me program is found in Appendix B.

Phase 1: Analysis

Members of the ACFD, Captain Terrence Greenfield and Captain Carol Saulnier (personal communication, February 3, 1999) learned of a similar program instituted in Prince William County, Virginia in February 1998. Greenfield and Saulnier requested information and recommendations from members of the Prince William County Department of Fire and Rescue. The Captains stated, after reviewing the Prince William information, they conferred on how to implement a similar program within the ACFD. They determined the best and most expeditious course was to replicate as much of the Prince William program as possible with adaptations for the Arlington County environment.

Task 1.1 - Identify organizational conditions; compare to existing mission, standards, values, and norms. There was no pre-existing, department-wide, CPR training effort by the ACFD since 1991 (Arlington County, Virginia, 1991, April). Greenfield and Saulnier (personal communication, February 19, 1999) determined that the ACFD environment was open to a program that allowed for a continuation of departmental provision of bystander CPR instruction without the need for payment of instructors and other associated programmatic overhead costs. They also determined that this initiative was consistent with the stated mission of the ACFD (Appendix C), viewed as an essential non-emergency service that the department could provide.

Task 1.2 - Identify potential destabilizing forces. Greenfield and Saulnier (personal communication, February 19, 1999) determined the potential destabilizing

forces were; (1) funding, (2) reluctance of the membership of the department to fulfill their roles and, (3) reluctance of the library system to become involved. No legal impediments were found (Saulnier, personal communication, February 3, 1999).

Task 1.3 - Assess impact of organizational conditions and potential destabilizing forces. This step was not formally taken as Greenfield and Saulnier (personal communication February 3, 1999) stated they were committed to overcoming any destabilizing force.

Task 1.4 - Determine organizational change requirements. The following organizational change requirements were determined:

(1) secure a continuous funding mechanism for the program,

(2) an attitudinal shift on the part of the membership of the ACFD was necessary (the membership needed to be convinced of the importance of their roles as marketers and support staff) and,

(3) A partnership needed to formed between the ACFD; the Arlington Professional Fire Fighters' and Paramedics' Association (APFPA), Local 2800 of the International Association of Fire Fighters, and; the Arlington County Department of Libraries (ACDL).

Phase II: Planning

Greenfield and Saulnier (personal communication, February 3, 1999) admitted that the majority of the planning phase of this project was done concurrent with the analysis. Adapting the Prince William model proved to be the single area needing the greatest planning, in particular, the formation of the partnership, especially with the ACDL. They stated that the ACDL needed to be shown the forces for this initiative were

much greater than the forces against and that the ACDL could leverage the goodwill generated by this program for other purposes, giving them another link with their patrons.

Task 2.1 - Systematically examine forces for and against change. As stated previously by Page (1985), CPR is "the most successful public health initiative since the polio vaccine." Also, as shown in the review of the literature, many CPR advocates were backing the notion of innovative, self-instruction methods; self-paced instruction; video as well as tactile skill training; instruction in the signs and symptoms of heart attack and actions to be taken, and; no requirement for certification testing. With this in mind, Greenfield and Saulnier (personal communication February 3, 1999) concluded that the forces for this initiative were monumental.

Forces against change were thought to be funding, the reluctance of the ACDL and the potential negative attitude of ACFD personnel over the program as an addition to their workload. There is no documentation, nor were there references to, either strengthening facilitative forces or reducing restraining forces.

Task 2.2 - Select personnel to develop vision of organizational change. The project documents, substantiated by Greenfield and Saulnier (personal communication February 3, 1999) envisioned the change being driven from the bottom-up. Bottom-up meaning that the vision of the program and the process to take it to implementation remained with the team rather than being established by the Chief of Department or other leadership.

Task 2.3 - Envision organizational change to be implemented. Greenfield and Saulnier (personal communication February 19, 1999) stated they followed the example set in the Prince William program however, because of the significant differences

between the two communities, the Arlington County revisions were necessary. They developed the roadmap for the Arlington County program. First, they sounded out the APFPA to see if financial support was available. The funding was available. Next was to secure the support of the ACFD, knowing that one of the restraining forces, finances, was partly taken care of by the APFPA. With the ACFD approval, next was the ACDL. The support already secured from the other two partners helped to persuade the ACDL to come on-board. Simultaneous with the overtures to the ACDL, Greenfield and Saulnier met with personnel at the Fire Station designated as the sanitation / re-supply station for the manikins.

Another difference that was taken into account was Arlington County's significant Hispanic population. The team decided to set up a number of the kits (video, materials and manikins) for Hispanic audiences. The video and all written materials in the kit were translated and published in Spanish.

Task 2.4 - Set/evaluate target goals/objectives of envisioned change. The program goals were set in the memorandum found in Appendix B. The goal, in general, was to have all citizens of Arlington County trained in CPR. The evaluation process for the program relied on a survey to be completed by the user of the program materials and returned with the materials. Additionally, ACDL kept a record of the circulation of the materials.

Task 2.5 - Assess and select method(s) of change to be employed. There was no discussion in the documentation or in the discussion with Greenfield and Saulnier regarding method of change as it relates to this project.

Task 2.6 - Assess and select techniques to promote change. Informational techniques were used to achieve approval from the three principle members of the partnership, the ACFD, the APFPA and the ACDL. Greenfield and Saulnier (personal communication February 3, 1999) stated the information was presented and all groups, which also created a dialogue and thus helped the program to come into reality. Attitudinal techniques were used on the employees who were needed to support the program, either at the ACFD or the ACDL. Greenfield and Saulnier (personal communication February 3, 1999) reported convincing them of the importance of the program and how their part was an integral part of the whole program.

Phase III: Implementation

Greenfield and Saulnier (personal communication February 3, 1999) indicated that they championed this project through all the partner agencies. Once all partners participation was assured through agreement in the Planning Phase they felt implementation, at least on a pilot level, was assured.

Task 3.1 – Create environment of shared vision and common direction. The Captains' stated that the shared vision employed they articulated came directly from the Prince William model. They persuaded the partner agencies that, through their participation, a true increase in the number of CPR trained bystanders could be achieved because Prince William County had shown a level of success with their version of the program. This vision was encapsulated in the goal statement found in the memorandum in Appendix B.

The vision and common direction was articulated to the members of the ACFD in Departmental Order 014-9902-3 and Standard Operating Procedure (SOP) CS-6, both

items are included in Appendix D. Promulgation of these documents assured sponsorship on the part of the ACFD and participation by its members.

Task 3.2 – Minimize initial resistance to change through effective communication. While Greenfield and Saulnier (personal communication February 3, 1999) stated there was little resistance to the program, the entire documented communication was the memorandum referenced in Appendix B. They stated they used the principles articulated in the memorandum as talking points when presenting the program to the APFPA and ACDL. Additionally, they reported that the Arlington County Government was in the process of motivating its departments to work together on projects and assist each other where it was appropriate. This fact was used to encourage ACDL into participating because a cooperative effort between the ACFD and the ACDL.

Communication to the target audience of this project was done through posters, pamphlets (see Appendix E) and through a program produced for Arlington County Cable TV Channel 31.

Task 3.3 – Create sense of urgency and pace for change. There was no reported sense of urgency for the implementation of the project on the part of the partner agencies; however, once advertised by the ACDL, a waiting list was established to check out the Rescue Me kits. As this waiting list grew, Saulnier (personal communication February 3, 1999) reported that a sense of urgency to complete the necessary supporting documents and procedures grew.

Task 3.4 – Develop and implement change enabling mechanisms. There was no discussion in the documentation or in the discussion with Greenfield and Saulnier regarding change-enabling mechanisms as it relates to this project. The only items that

could be viewed as either a practical or symbolic change enabling mechanism was the documents published by the ACFD and the publicity published by the program partners.

Task 3.5 – Implement planned change methods and techniques. The envisioned implementation was articulated in the requesting memorandum (Appendix B). How actual implementation was to occur was identified in the Departmental Order and SOP published by the ACFD (Appendix D). By publishing the outline of the project in these two documents, commitment of the part of the ACFD, and to a limited extent the APFPA, was articulated. Additionally, the commitment of the personnel of the ACFD who agreed to be part of the program (in particular those who were going to sanitize and re-stock the kits) was affirmed and the responsibilities of all other members of the ACFD was assured.

Phase IV – Evaluation / Institutionalism

Each Rescue Me kit includes an evaluation form for the program. Participants are requested to complete and return the evaluation with the kit. Spanish language kits have identical forms in Spanish. Examples of these forms are found in Appendix F.

Task 4.1 – Evaluate initial change implementation. The initial program goals were established in the memorandum found in Appendix B. The evaluation process for the program relied on a survey to be completed by the user of the program materials and returned with the materials. Additionally, ACDL kept a record of the circulation of the materials. The only true goal articulated by the program team was that "all citizens of Arlington County will have the skills to provide CPR". The survey (Appendix F) and the circulation records of each kit evaluated this aspect. The survey included a question regarding the total number of participants would used the kit while it was checked out.

ACDL recorded, through its circulation records, how many times each kit was checked out. Both items provided data to determine the total number of participants.

Additional questions on the survey requested information on how the participants found out about the program, so that one aspect of the communications plan could be evaluated, and confidence developed by the user in their ability to perform CPR.

No plan for how the data would be used to evaluate the stated program goal was articulated. Also, there was no plan articulated to determine if the participants actually learned the desired skills. No instruments were developed to evaluate cost, unanticipated actions or occurrences, or initial resistance to the program on the part of the ACFD membership or the ACDL staff who were involved.

Task 4.2 – Alter / modify change management approach. No alteration or modification approach was stated in the program documents or by the development team, Captains Greenfield and Saulnier. In addition, they stated that the program was too new to have sufficient data to indicate a need to change the original approach.

Task 4.3 – Continue to monitor and institutionalize change implementation. Greenfield and Saulnier (personal communication February 3, 1999) stated that returned surveys are recorded in a database for future review and that the program was too new to have sufficient experience to state that the program was institutionalized. Also, nothing was in the plan to encourage or reward participants (either users or support staff) to continue the program or encourage others to utilize the program to gain CPR skills.

Assumptions and Limitations

The first assumption made regarding this project was use of the NFA's Change Management Model as the basis for analyzing the implementation of the Rescue Me

program. The Change Management Model, being the core of the NFA's *Strategic Management of Change* course, was viewed as being valid and therefore appropriate standards with which to assess this change process. Challenges to the Change Management Model were not investigated and were not part of this project.

Second, the advocacy for training the general public in CPR, as espoused by the AHA and others (viz. Newman, 1988; Eisenberg et al., 1990; Spaite et al., 1990; Swor et al., 1995; Newman, 1997) was not in question. The literature was reviewed for the purpose of evaluating the methods of CPR training being adopted through this change mechanism. This was done to support or refute the analysis performed as Task 1.1 of the model only.

Last, the Change Management Model is largely a model for organizational change and not necessarily a model for project management. The model however, does call for a systematic and progressive movement from beginning through to institutionalizing a new concept either as part of, or the whole organization. (NFA, 1996, 2-3).

RESULTS

Answers to Research Questions

Research Question 1. Captain Terrence Greenfield (personal communication, February 19, 1999) stated that he had learned of efforts by the Prince William County, Virginia Department of Fire and Rescue to implement a video based, self-instruction, CPR training program, as he was a resident of that locality. He stated he contacted Captain Carol Saulnier, who he knew to be interested in CPR instruction for the general public, and discussed this matter. Information on the Prince William County program

was solicited and reviewed. They together developed the implementation memorandum found in Appendix B.

Research Question 2. Steps taken to implement the Rescue Me program generally followed the NFA's Change Management Model. Analysis of the pre-existing situation, conformity to ACFD values and mission, identification of potential destabilizing forces and a determination of change requirements were performed as a first order of work. Planning was chosen as a second order of work and included: examination of forces for and against this project, deciding to keep the leadership of this project driven in a bottom-up method, envisioning of the final results of the project, setting target goals, and selection of promotional methods.

Implementation of the project was subsequently performed. During the Implementation phase, the following tasks were performed: the creation and dissemination of a shared vision of the project, communication of the vision to reduce initial resistance, and the actual implementation of the project. Evaluation, as the last order of work, included collection of raw data from participants only.

Research Question 3. All tasks within the Analysis phase were performed. The assessment and selection of the method of change to be employed by this project was not discussed as part of the Planning phase. During the Implementation phase, the need to create a sense of urgency was not performed as the project was creating its own pace and no change enabling mechanisms was developed. As stated under the previous question, the only portion of the Evaluation and Institutionalization phase performed was the development of a survey instrument for program participants. The survey that is part of the program does not collect the information necessary to check if the program is meeting

the stated goal. Alterations or modifications of the program have not been performed or contemplated. Lastly, no rewards or other encouragement mechanism was articulated to support the continuation of the program.

DISCUSSION

The analysis of the methods employed in developing and initiating the ACFD's Rescue Me program against the template of the NFA's Change Management Model reveal both consistencies and inconsistencies. First, the analysis, planning and implementation phases generally followed the NFA model. Some tasks were performed simultaneously (e.g. analysis and planning), but for the most part, the progression from the genesis of the idea, to development of the program, through to the implementation, largely followed the course set out in the model. The items of the model that were not used, an actual assessment and selection of the method of change, did not prevent the program from progressing to full implementation.

A review of the actual results of performing each task reveals a potential error, that being the establishment of a proper goal of the project. The goal, "All citizens of Arlington County will have the skills to provide CPR," while laudable, does not pass the tests of being explicit, precise, and quantifiable (Task 2.4) (NFA, 1996, 2-9) or even attainable. With this being the sole goal of the program, it would appear extremely difficulty to determine the attainment of the goal or any progress toward attaining it. This could lead to an inability to feel good about achievements made by participants in the program, program staff or the program itself.

The more critical elements of the NFA model not used with this program appear to be in the final phase, Evaluation and Institutionalization. While course evaluations

(Appendix F) are an important part of evaluation of the program, it is not complete and cannot be the sole evaluation tool. Even with the good data that the survey collects, there is misalignment between those items and the stated goal of the program. The program goal and the evaluation tools need to relate to each other (NFA, 1996, 2-9). The stated program goal, because it lacked the critical traits of being explicit, precise and quantifiable, did not lead to evaluation tools that would give the project leadership clues as to whether or not the goal was being achieved. Without knowing whether the program is moving toward its stated goal or not, reinforcements for movement toward the goal cannot be given. Likewise, movement away from the stated goal cannot be determined and therefore cannot be corrected.

RECOMMENDATIONS

The ACFD should revise the goal for the Rescue Me program to one or more that meet the requirements (explicit, precise and quantifiable) consistent with Task 2.4 of the Change Management Model. Following the adoption of these revised goals, appropriate evaluation tools should be implemented to allow for analysis of trends, meeting of milestones and ultimately, the attainment of new goals. Reaching milestones should also lead to appropriate celebrations of achievement for the program. These celebrations would give the program additional positive momentum, helping to progress toward the new goal and toward institutionalizing the program within the ACFD.

The program should continue to gather the demographic data currently being collected. From a scientific standpoint, this program is a new method for training the general public in CPR and could be shown to be effective. The program should consider testing some of those who complete this method of training against those who take CPR

training in the traditional method. The results of this study could show the efficacy of this training method or conversely, recommend its abandonment.

Reports of the program analysis should be shared with the AHA and others involved in CPR training. Data from programs such as this are not common and publishing the data could add to the collective body of knowledge on this subject.

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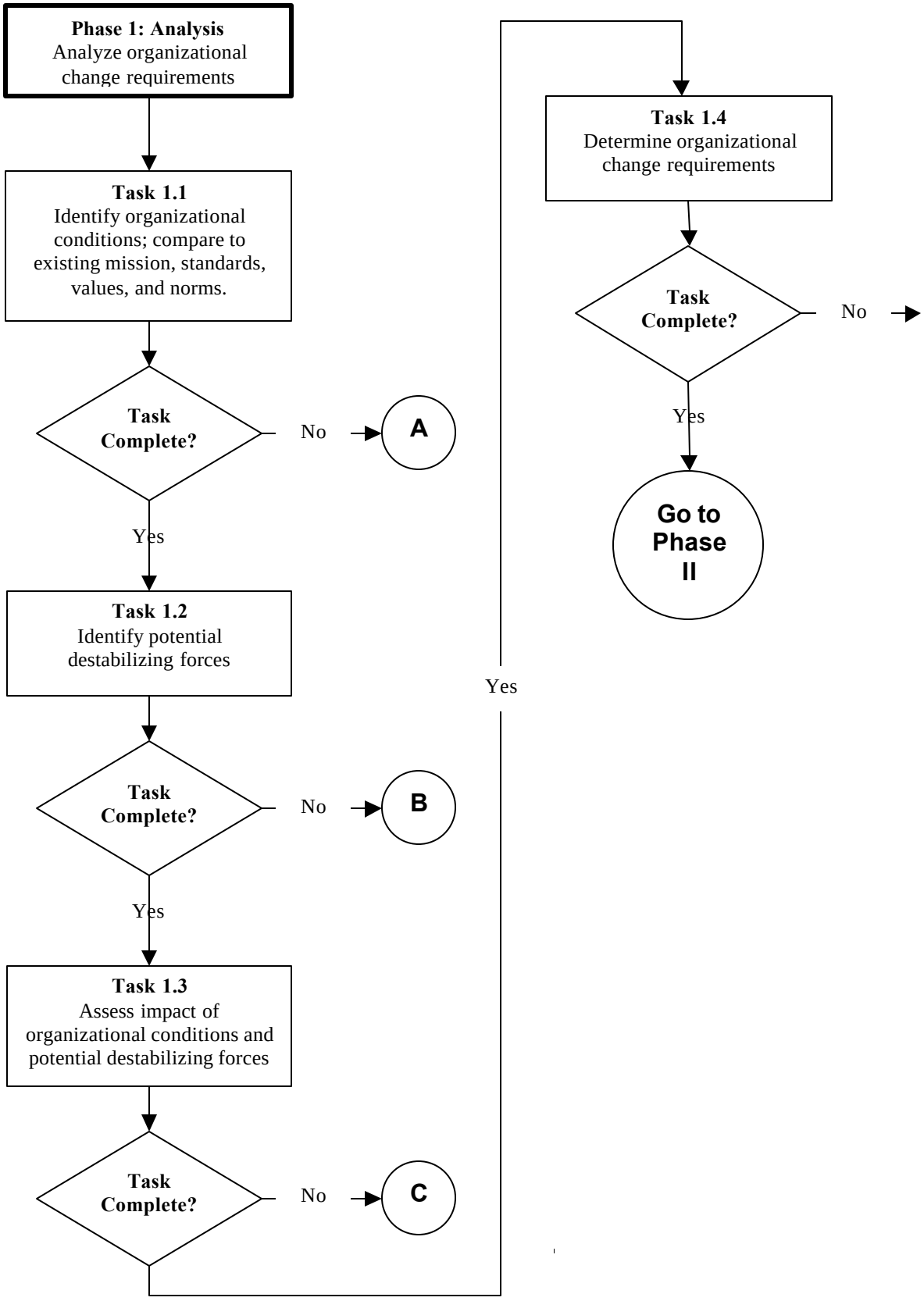
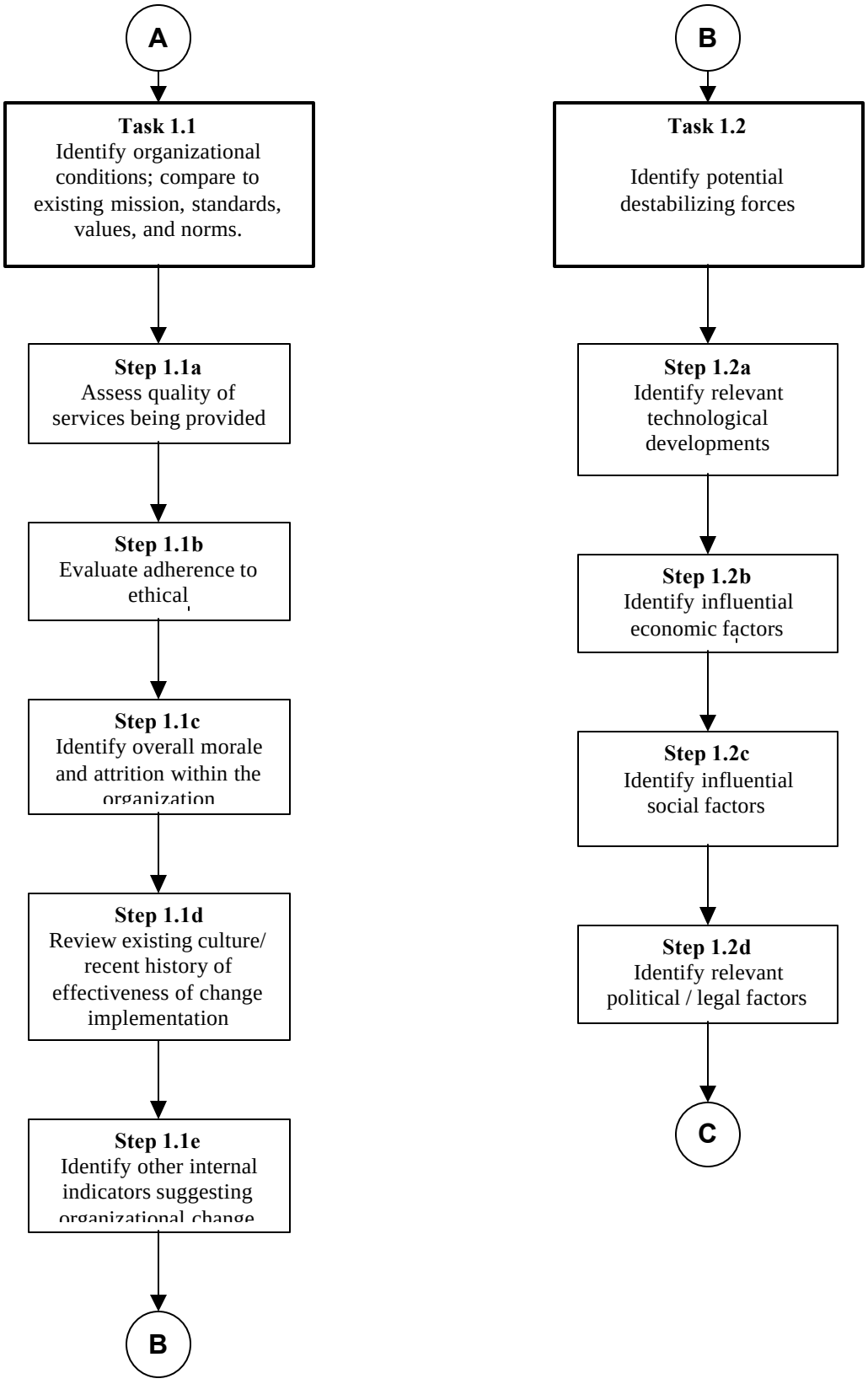
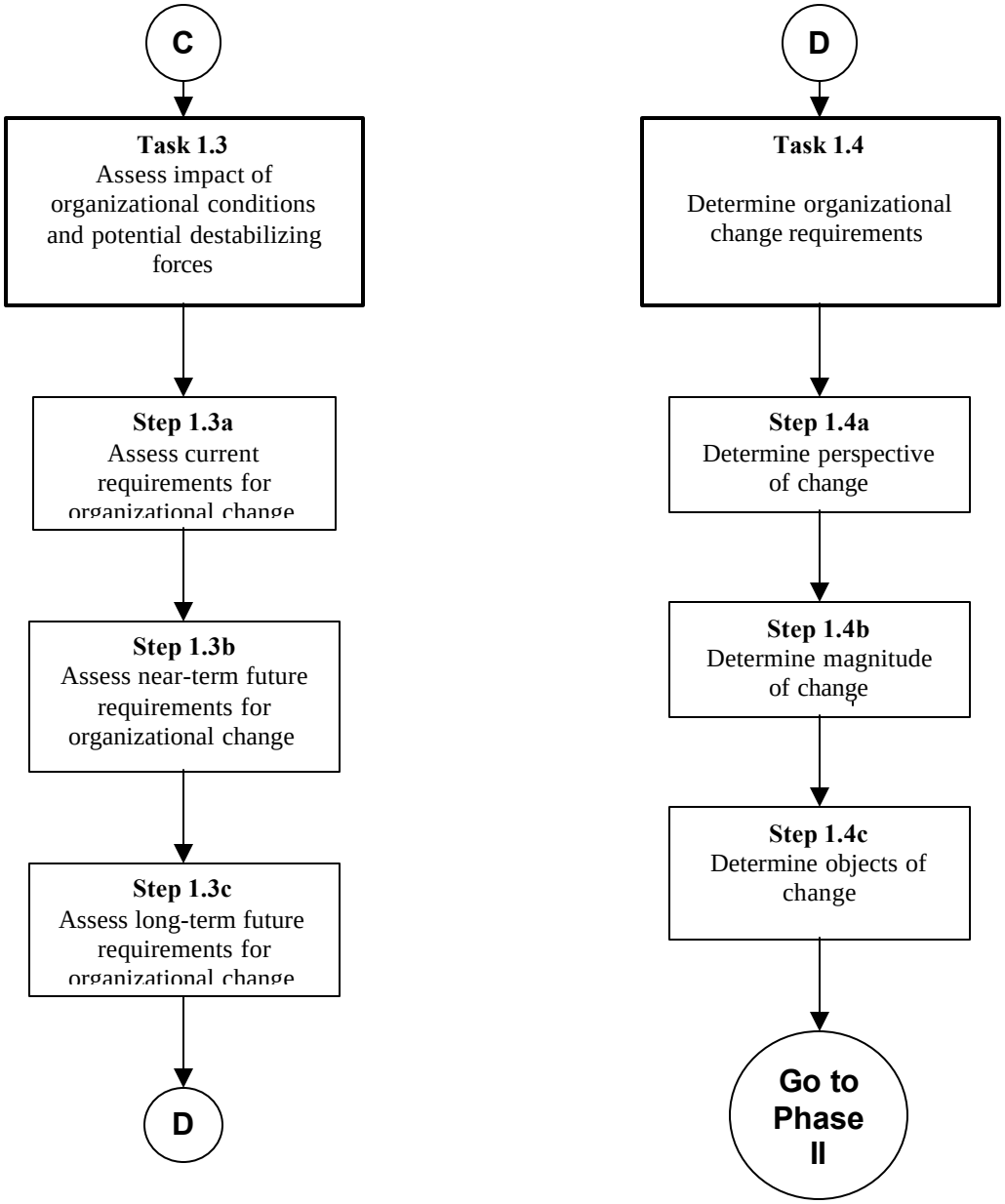
APPENDIX A

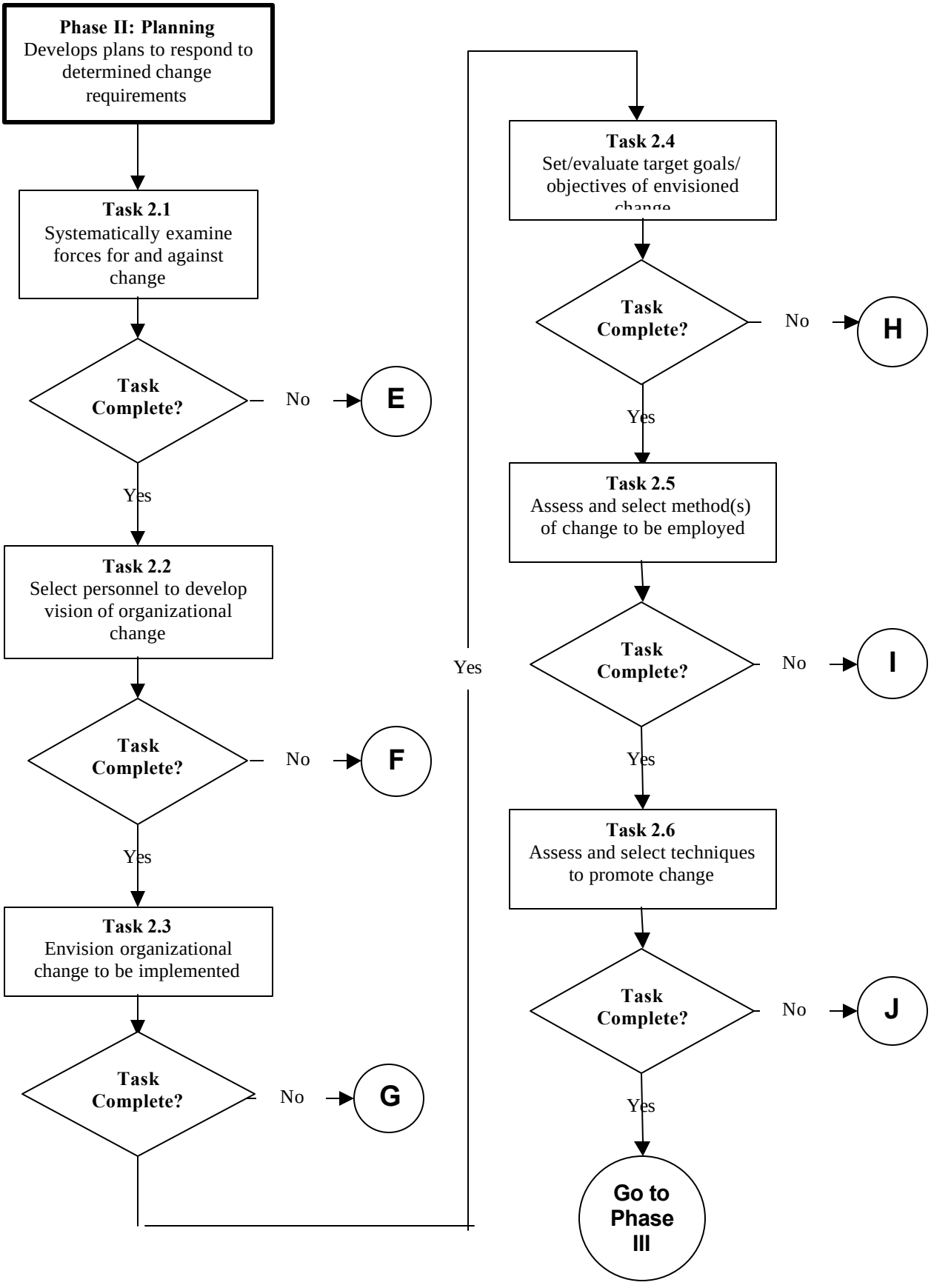
CHANGE MANAGEMENT MODEL

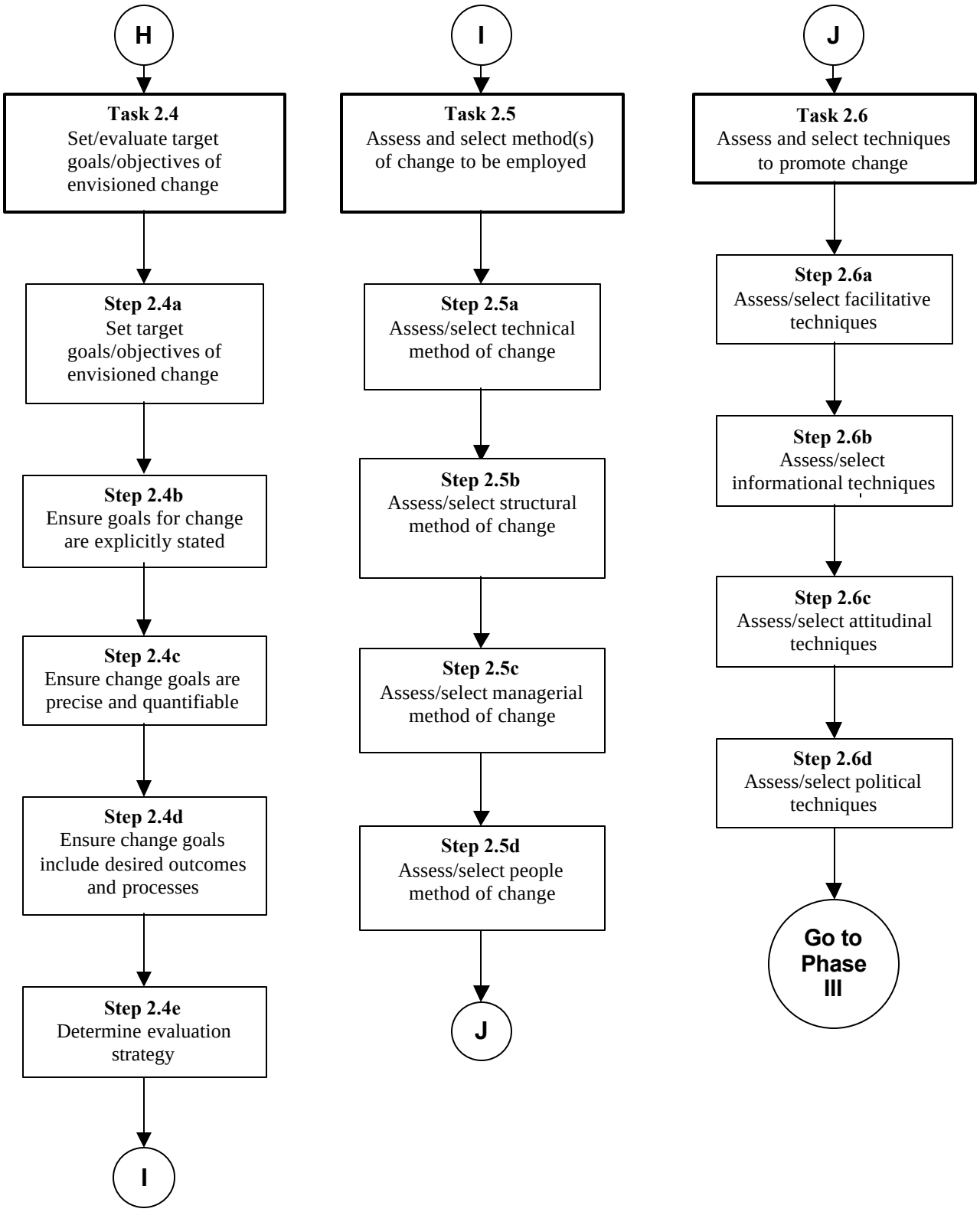
CHANGE MANAGEMENT MODEL

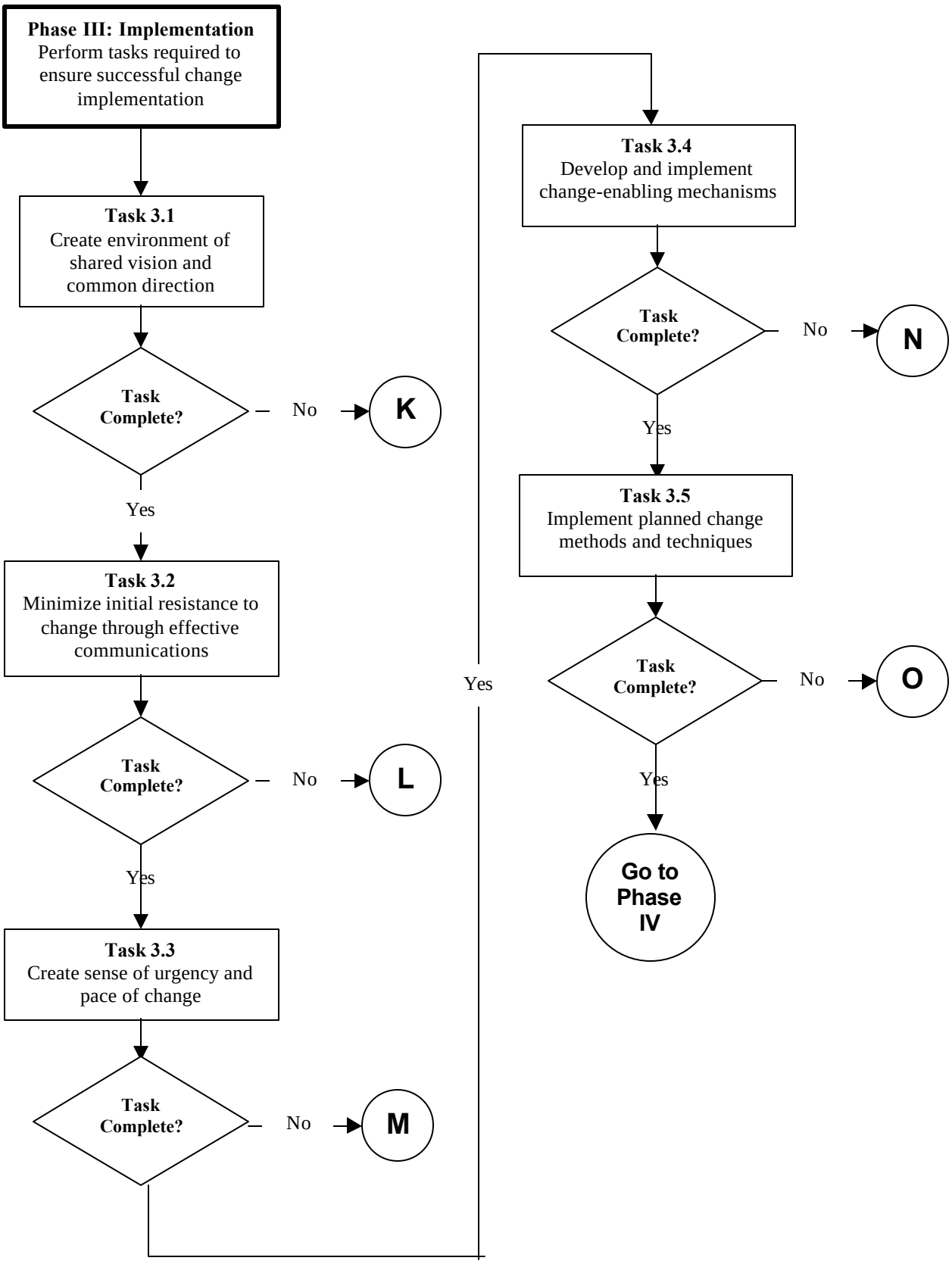


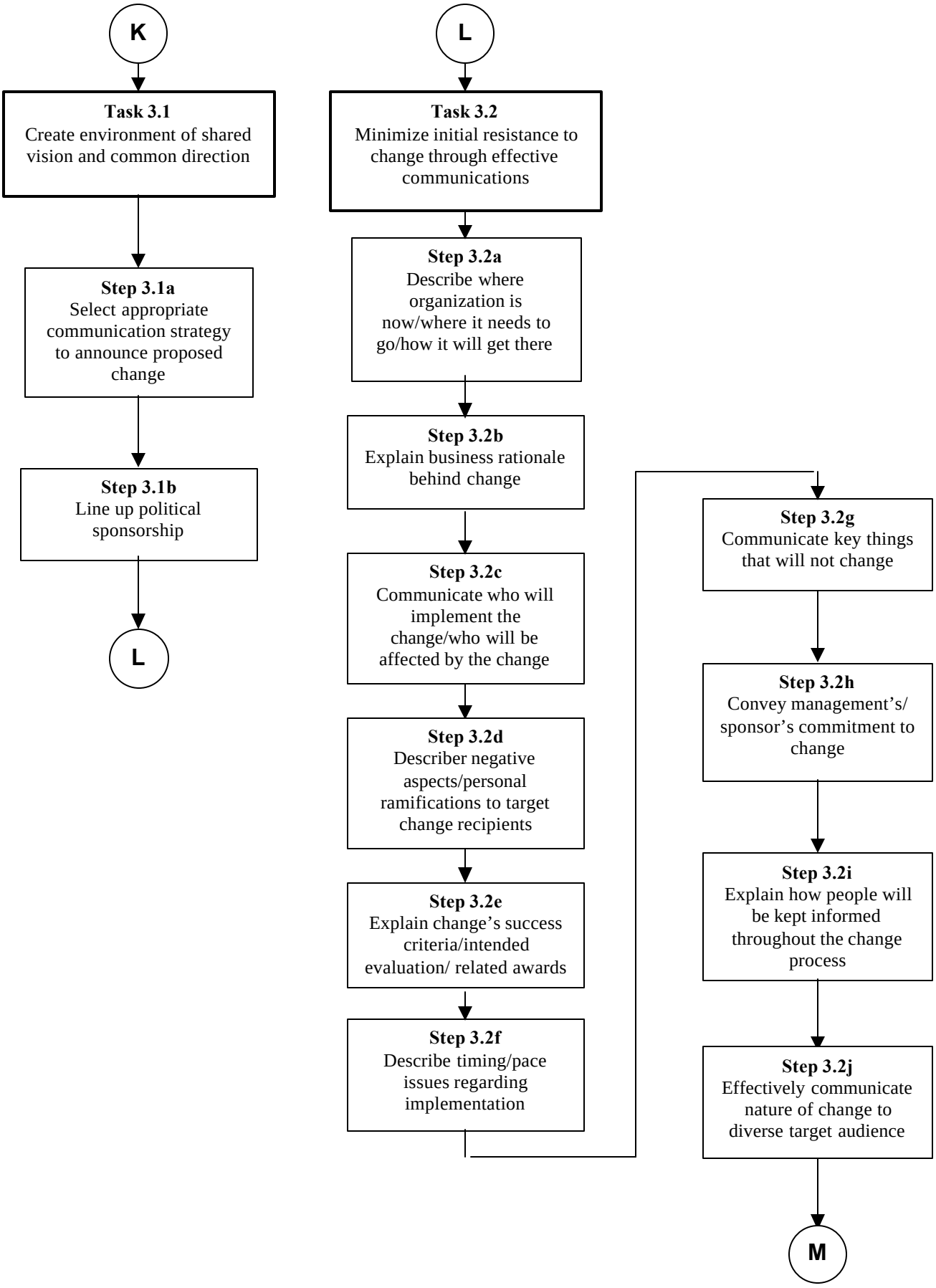

A
Task 1.1
Identify organizational conditions; compare to existing mission, standards, values, and norms.
Step 1.1a
Assess quality of services being provided
Step 1.1b
Evaluate adherence to ethical
Step 1.1c
Identify overall morale and attrition within the organization
Step 1.1d
Review existing culture/ recent history of effectiveness of change implementation
Step 1.1e
Identify other internal indicators suggesting organizational change
B
B
Task 1.2
Identify potential destabilizing forces
Step 1.2a
Identify relevant technological developments
Step 1.2b
Identify influential economic factors
Step 1.2c
Identify influential social factors
Step 1.2d
Identify relevant political / legal factors
C

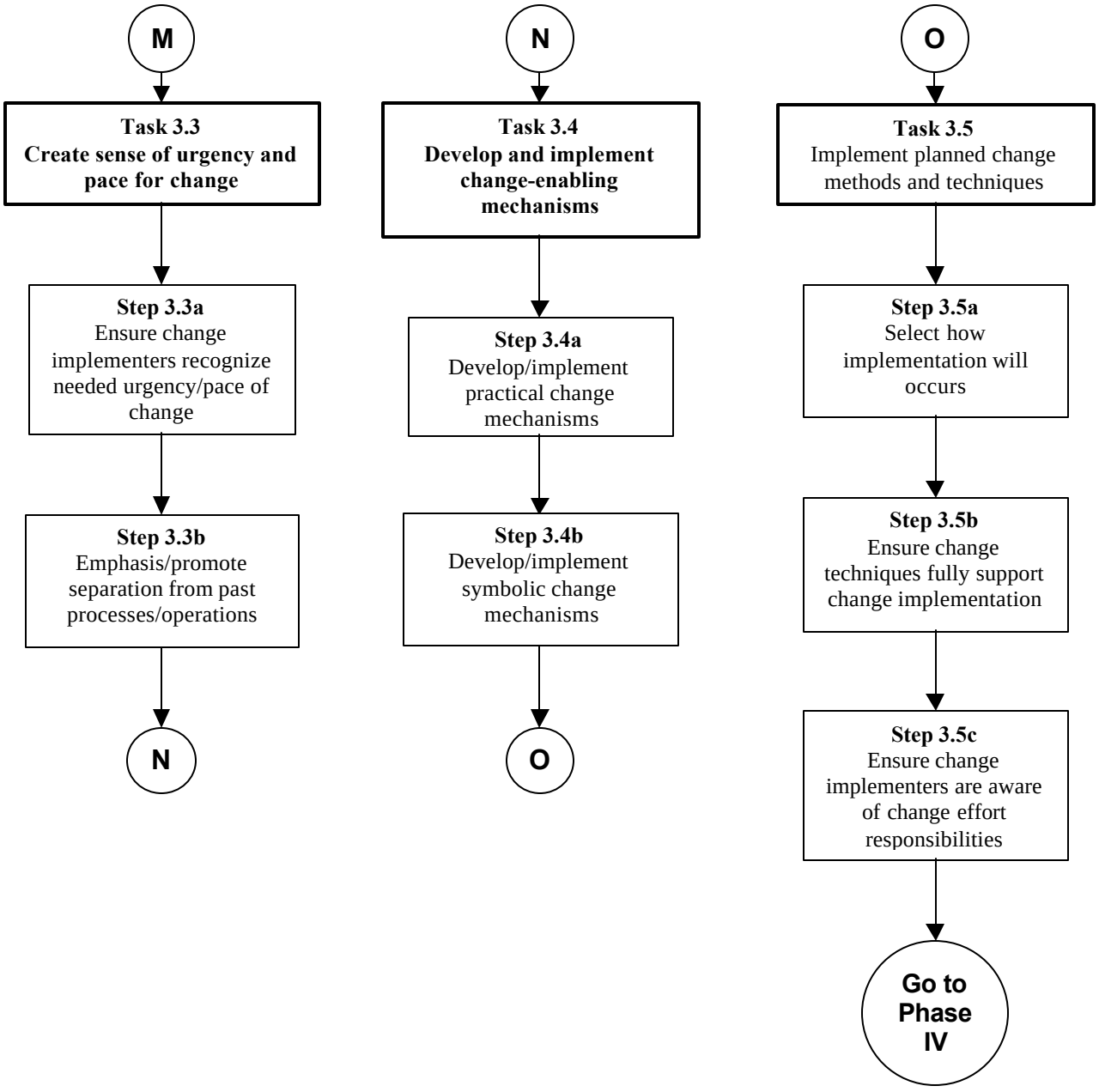

C
Task 1.3
Assess impact of organizational conditions and potential destabilizing forces
Step 1.3a
Assess current requirements for organizational change
Step 1.3b
Assess near-term future requirements for organizational change
Step 1.3c
Assess long-term future requirements for organizational change
D
D
Task 1.4
Determine organizational change requirements
Step 1.4a
Determine perspective of change
Step 1.4b
Determine magnitude of change
Step 1.4c
Determine objects of change
Go to Phase II

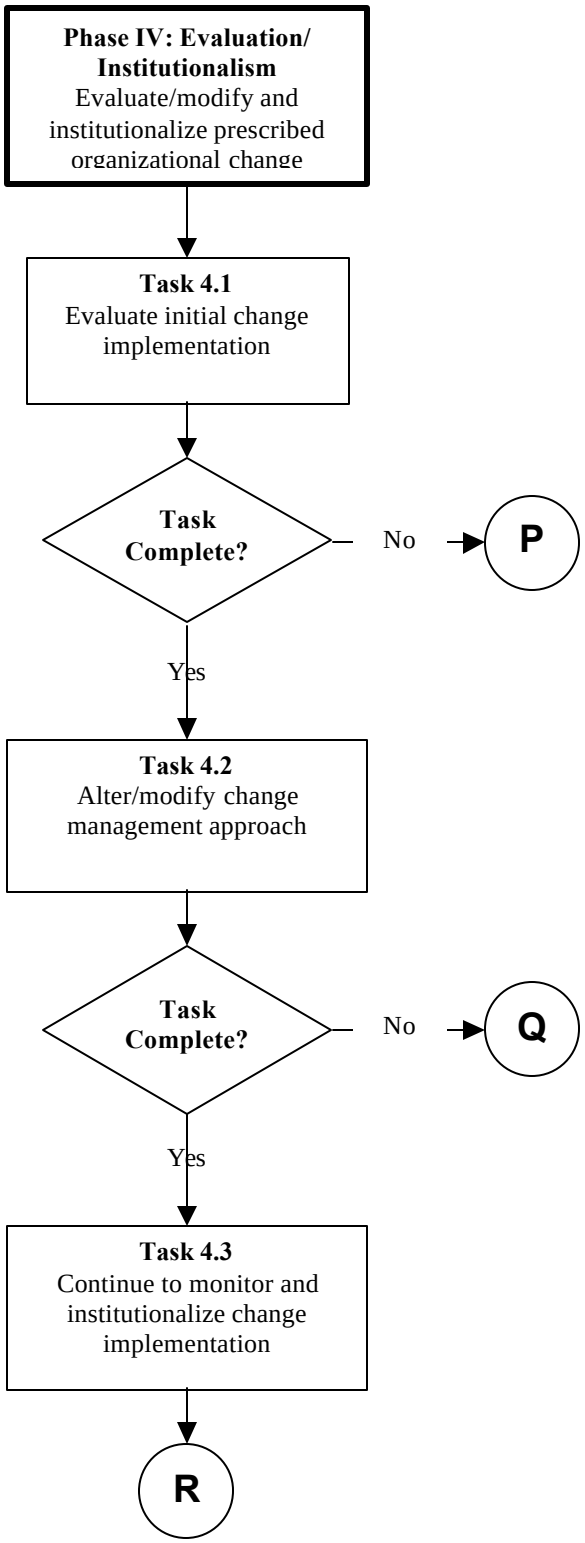

Phase II: Planning
Develops plans to respond to determined change requirements
Task 2.1
Systematically examine forces for and against change
Task Complete?
No
E
Yes
Task 2.2
Select personnel to develop vision of organizational change
Task Complete?
No
F
Yes
Task 2.3
Envision organizational change to be implemented
Task Complete?
No
G
Yes
Task 2.4
Set/evaluate target goals/ objectives of envisioned change
Task Complete?
No
H
Yes
Task 2.5
Assess and select method(s) of change to be employed
Task Complete?
No
I
Yes
Task 2.6
Assess and select techniques to promote change
Task Complete?
No
J
Yes
Go to Phase III

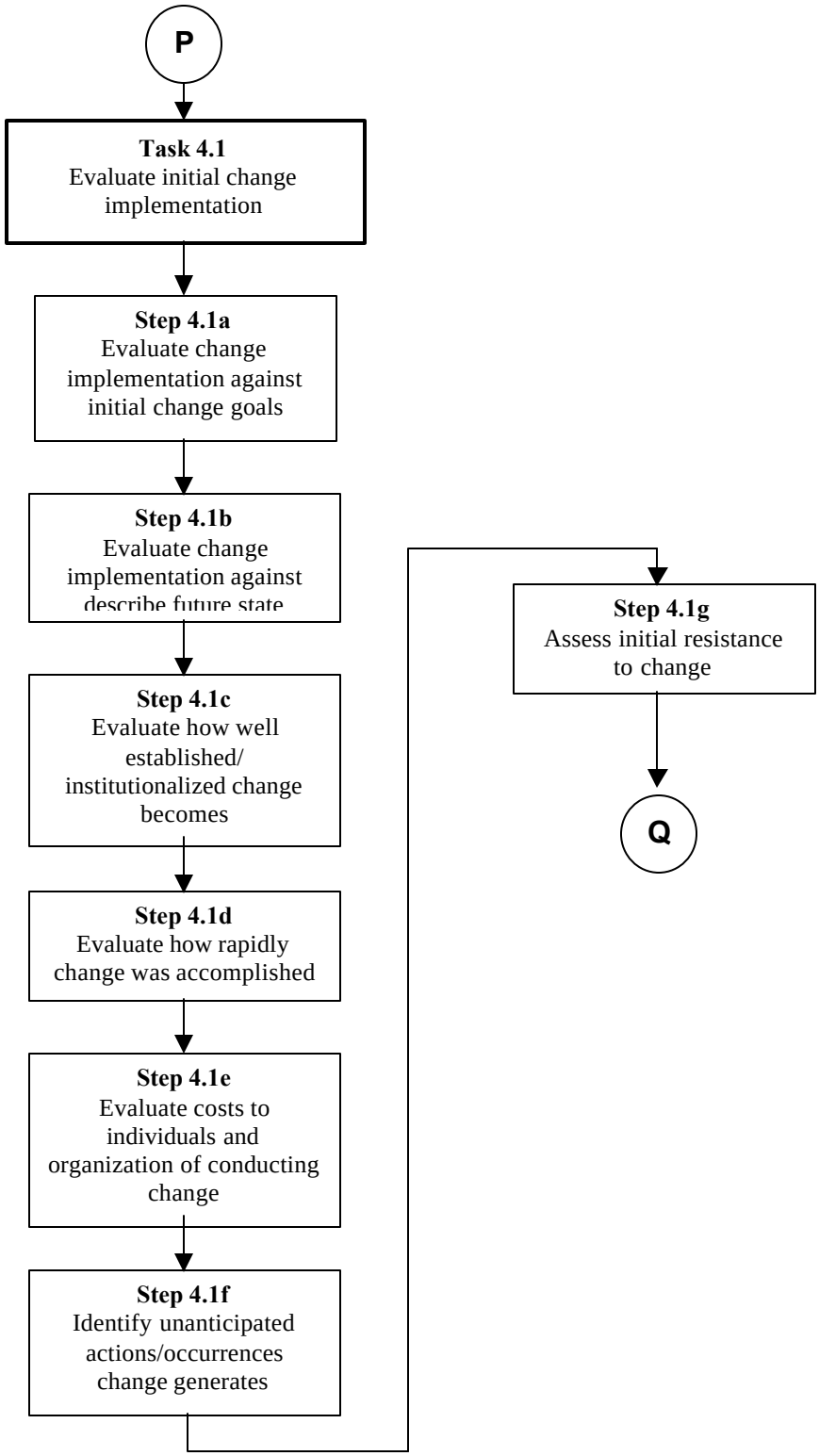

H
Task 2.4
Set/evaluate target goals/objectives of envisioned change
Step 2.4a
Set target goals/objectives of envisioned change
Step 2.4b
Ensure goals for change are explicitly stated
Step 2.4c
Ensure change goals are precise and quantifiable
Step 2.4d
Ensure change goals include desired outcomes and processes
Step 2.4e
Determine evaluation strategy
I
I
Task 2.5
Assess and select method(s) of change to be employed
Step 2.5a
Assess/select technical method of change
Step 2.5b
Assess/select structural method of change
Step 2.5c
Assess/select managerial method of change
Step 2.5d
Assess/select people method of change
J
J
Task 2.6
Assess and select techniques to promote change
Step 2.6a
Assess/select facilitative techniques
Step 2.6b
Assess/select informational techniques
Step 2.6c
Assess/select attitudinal techniques
Step 2.6d
Assess/select political techniques
Go to Phase III

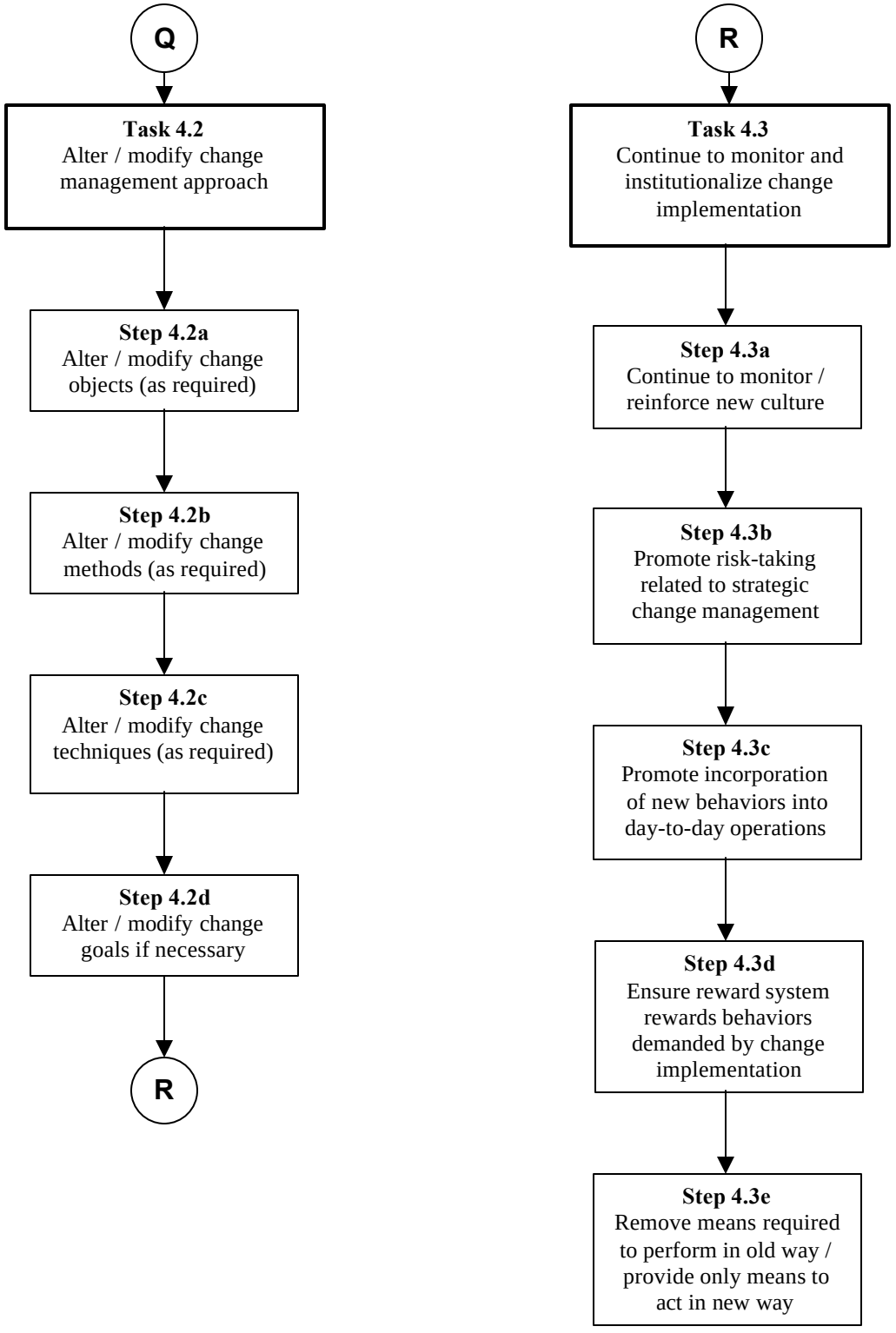

Phase III: Implementation
Perform tasks required to ensure successful change implementation
Task 3.1
Create environment of shared vision and common direction
Task Complete?
No
K
Yes
Task 3.2
Minimize initial resistance to change through effective communications
Task Complete?
No
L
Yes
Task 3.3
Create sense of urgency and pace of change
Task Complete?
No
M
Yes
Task 3.4
Develop and implement change-enabling mechanisms
Task Complete?
No
N
Yes
Task 3.5
Implement planned change methods and techniques
Task Complete?
No
O
Yes
Go to Phase IV


K
Task 3.1
Create environment of shared vision and common direction
Step 3.1a
Select appropriate communication strategy to announce proposed change
Step 3.1b
Line up political sponsorship
L
L
Task 3.2
Minimize initial resistance to change through effective communications
Step 3.2a
Describe where organization is now/where it needs to go/how it will get there
Step 3.2b
Explain business rationale behind change
Step 3.2c
Communicate who will implement the change/who will be affected by the change
Step 3.2d
Describer negative aspects/personal ramifications to target change recipients
Step 3.2e
Explain change's success criteria/intended evaluation/ related awards
Step 3.2f
Describe timing/pace issues regarding implementation
Step 3.2g
Communicate key things that will not change
Step 3.2h
Convey management's/ sponsor's commitment to change
Step 3.2i
Explain how people will be kept informed throughout the change process
Step 3.2j
Effectively communicate nature of change to diverse target audience
M


M
Task 3.3
Create sense of urgency and pace for change
Step 3.3a
Ensure change implementers recognize needed urgency/pace of change
Step 3.3b
Emphasis/promote separation from past processes/operations
N
N
Task 3.4
Develop and implement change-enabling mechanisms
Step 3.4a
Develop/implement practical change mechanisms
Step 3.4b
Develop/implement symbolic change mechanisms
O
O
Task 3.5
Implement planned change methods and techniques
Step 3.5a
Select how implementation will occurs
Step 3.5b
Ensure change techniques fully support change implementation
Step 3.5c
Ensure change implementers are aware of change effort responsibilities
Go to Phase IV


Phase IV: Evaluation/ Institutionalism
Evaluate/modify and institutionalize prescribed organizational change
Task 4.1
Evaluate initial change implementation
Task Complete?
No
P
Yes
Task 4.2
Alter/modify change management approach
Task Complete?
No
Q
Yes
Task 4.3
Continue to monitor and institutionalize change implementation
R


P
Task 4.1
Evaluate initial change implementation
Step 4.1a
Evaluate change implementation against initial change goals
Step 4.1b
Evaluate change implementation against describe future state
Step 4.1c
Evaluate how well established/ institutionalized change becomes
Step 4.1d
Evaluate how rapidly change was accomplished
Step 4.1e
Evaluate costs to individuals and organization of conducting change
Step 4.1f
Identify unanticipated actions/occurrences change generates
Step 4.1g
Assess initial resistance to change
Q


Q
Task 4.2
Alter / modify change management approach
Step 4.2a
Alter / modify change objects (as required)
Step 4.2b
Alter / modify change methods (as required)
Step 4.2c
Alter / modify change techniques (as required)
Step 4.2d
Alter / modify change goals if necessary
R
R
Task 4.3
Continue to monitor and institutionalize change implementation
Step 4.3a
Continue to monitor / reinforce new culture
Step 4.3b
Promote risk-taking related to strategic change management
Step 4.3c
Promote incorporation of new behaviors into day-to-day operations
Step 4.3d
Ensure reward system rewards behaviors demanded by change implementation
Step 4.3e
Remove means required to perform in old way / provide only means to act in new way

APPENDIX B

INITIATING MEMORANDUM

RESCUE ME PROGRAM

ARLINGTON COUNTY, VIRGINIA
INTER-DEPARTMENTAL MEMORANDUM

DATE: November 18, 1998

TO: Chief James Schwartz

FROM: Capts. Greenfield and Saulnier

SUBJECT: Rescue Me Program

Program Goal:

- All citizens of Arlington County will have the skills to provide CPR.

Activities:

- Have self-instructional CPR available to all citizens of Arlington County.
- Promote and market the program to ensure community awareness and participation.
- Establish a continuous funding mechanism.
- Provide a process for citizens to obtain additional training.
- Program will be available through a partnership between the Arlington Professional Firefighters Association, the Arlington County Fire Department, and the Arlington County Public Libraries.

The Process:

- Any person with a library card can go to the Columbia Pike or Aurora Hills library branch to check out or reserve a self-instructional CPR kit.
- The citizen uses the kit and returns it.
- The library courier delivers the kit to the fire department for cleaning.
- The kit is cleaned, disinfected, resupplied and sealed.
- The kit is returned to library circulation.

APPENDIX C

MISSION STATEMENT

ARLINGTON COUNTY FIRE DEPARTMENT

APPENDIX C

MISSION STATEMENT

The mission of the Arlington County Fire Department is to provide essential emergency and non-emergency services.

We are a quality organization dedicated to answering the needs of the Community with highly skilled people who care. We are committed to eliminating the threats to life safety and property through education, prevention and effective response to fire, medical and environmental emergencies. We will achieve our mission through teamwork, professionalism and a commitment to the people we serve.

APPENDIX D

RELATED

ARLINGTON COUNTY FIRE DEPARTMENT

DEPARTMENTAL ORDERS

AND

STANDARD OPERATING PROCEDURES

TRAINING

This copy for _____

Arlington County, Virginia
Fire Department

Date: February 10, 1999

Subject: Departmental Order #014-9902-3
"Rescue Me" CPR Program

Fire Chief's Approval

To: All Personnel

From: James H. Schwartz, Assistant Chief, Operations JHS

Rationale: To inform all members of the new "Rescue Me" program available at the County libraries.

Text: The Fire Department, along with the Arlington Professional Firefighters and Paramedics Association (APFPA) and the Department of Libraries will be starting a self-instructional CPR learning program beginning the week of February 14, 1999.

This program consists of 20 CPR Prompt kits that were jointly purchased by the Department and the APFPA. The kits consist of an adult/child mannequin, infant mannequin, battery-operated CPR rescue and practice aid, CPR instructional video and books. The kits are available in both English and Spanish at Aurora Hills, Cherrydale and Columbia Pike branches. The kits have been distributed to the Library Department and will be available to all citizens with a library card. Borrowers may take the kits home and learn CPR at their own pace. Although the American Heart Association recognizes the kits, taking the course at home will not result in CPR certification.

The library courier will use station 5 as an exchange point, with the members of station 5 performing necessary maintenance to return the kits to circulation.

c. All Order Books — Departmental Order #014-9902-3
Please read and initial: — Expires: December 31, 1999

Personnel that have questions concerning this Departmental Order are directed to contact their immediate supervisor for clarification or interpretation. If the immediate supervisor cannot answer the inquiry, the immediate supervisor is to continue through the chain-of-command until the inquiry is answered.

A PLATOON B PLATOON C PLATOON STAFF VOLUNTEERS

	ARLINGTON COUNTY FIRE DEPARTMENT STANDARD OPERATING PROCEDURE	
	OPERATIONS DIVISION	
	SUBJECT: Rescue Me Program	SOP# OPS CS 6
	APPROVED: James H. Schwartz, Jr. Assistant Chief - Operations JHS	Initiated 02/14/99
	APPROVED: Edward P. Plaugher Fire Chief	Revised

A. PURPOSE

To provide procedures and guidelines for implementing the "Rescue Me" self-instructional C.P.R. program.

B. GENERAL

"The Rescue Me" kit is a partnership between the Fire Department, the Department of Libraries and the Arlington Professional Firefighters & Paramedics Association. The program is an effort to promote the training of C.P.R. to the citizens of Arlington County by making available self-instructional C.P.R. kits through County Libraries. Members at Fire Station 5 have agreed to maintain the kits as the library exchanges them.

C. RESPONSIBILITIES

1. Company Officers at Station 5

a. Provide space for storing and servicing the kits.

b. Assign personnel to service and maintain the kits to be exchanged with the library.

c. Contact the Public Education Officer for parts, printed material, and other maintenance items or to report missing or damaged items.

d. Forward customer surveys to the Public Education Officer.

2. Personnel assigned to Station 5.

a. Clean and prepare kits for exchange by the library courier.

b. Inform the company officer of needed supplies or parts to maintain the kits.

3. **Public Education Officer**

   a. Respond to inquiries from the pubic requesting information about the program.

   b. Provide parts and supplies to Sstation 5 personnel for maintaining the kits.

   c. Maintain and compile a database of all customer survey responses.

D. PROCEDURE

1. The libraries will initially have approximately 15 kits available for immediate distribution among three libraries: Aurora Hills, Cherrydale, and Columbia Pike. Five kits will be assigned to Station 5 to be used for exchange.

2. Anyone with a library card may checkout the kit at the library.

3. When the kit is returned to the library, the library courier will drop it off at Station 5 and pick-up a clean kit to be re-circulated.

4. The personnel at Station 5 shall clean and restock the kit following proper procedures. Customer surveys will be forwarded to the Public Education Officer as necessary.

5. The Pubic Education Officer shall maintain the results of the customer surveys and forward pertinent information to the Assistant Chief of Operations and the library's Director of Public Service as needed.

END

APPENDIX E

Rescue Me Program

PROMOTIONAL PAMPHELT AND POSTER

LEARN CPR AT HOME

AVAILABLE AT FOLLOWING LIBRARIES

CHERRYDALE-AURORA HILLS-COLUMBIA PIKE

RESCUE ME

LEARN

ADULT
CHILD
INFANT
CHOKING

Department of Libraries

A self-instructional CPR program sponsored by the Arlington Professional Firefighters and Paramedics Association, the Arlington County Library Department, and the Arlington County Fire Department

FOR INFORMATION CALL:
228-4659

Individuals are encouraged to use **Rescue Me** to practice or to refresh their skills. We also recommend you take a CPR certification class.

TO CONTACT US

For information about the **Rescue Me** Program, contact:

Arlington County Fire Department
Telephone: (703) 228-4659
TTY: (703) 228-4610
Fax: (703) 228-4655
Email: kvangr@co.arlington.va.us

For information on CPR certification classes, call:

The American Heart Association
Telephone: (703) 941-8500

Made possible through a partnership of the following organizations:

Arlington Professional Firefighters Association, Local 2800 IAFF

Arlington County Fire Department

Department of Libraries

ARLINGTON COUNTY FIRE DEPARTMENT
2100 CLARENDON BOULEVARD, SUITE 400
ARLINGTON, VIRGINIA 22201

Rescue Me
CPR Program

LEARN CPR

- In your own home
- At your convenience
- At no cost

HOW?

- Go to your library.
- Request the **Rescue Me** Kit.
- Check it out, take it home.

WHAT IS RESCUE ME?

- It is a self-instruction CPR program.
- The kit contains a step-by-step video and practice mannequin.
- A video guides viewer through CPR procedure.
- It makes learning CPR easy.
- All you need is a VCR and a library card.

Rescue Me
CPR Program

WHAT?

Rescue Me is an important new community-wide lifesaving program. This free program provides an opportunity to learn CPR in your own home at no cost.

WHY?

Because only 30 percent of the population is trained in CPR, a new method to enable more people to learn this critical lifesaving skill has been introduced.

WHO?

Rescue Me is for anyone, especially if you have a high-risk individual at home; *e.g.,* someone with a history of cardiac or respiratory problems. Families with young children or elderly at home could gain some peace of mind, as well.

HOW?

Anyone with a library card can check out a **Rescue Me** kit from Aurora Hills, Cherrydale or Columbia Pike Library. All you need is access to a videocassette recorder to view the step-by-step videotape.

STAGGERING STATISTICS

1. More than 70 percent of all cardiac emergencies occur in the home when a family member is present.
2. Over 1.5 million heart attacks occur each year, and approximately 250,000 of these people die before ever reaching the hospital.
3. Fewer than seven percent of people suffering cardiac arrest outside the hospital survive.
4. When breathing stops, a person typically can survive for only four to six minutes before lack of oxygen starts to cause brain damage or death. CPR helps extend this four-to-six minute window by artificially circulating blood and oxygen to the brain until professional help arrives.
5. Between 100,000 and 200,000 lives could be saved each year if CPR were performed early enough, according to the American Heart Association.
6. CPR is not just for heart attacks. Over 16 million children end up in the hospital each year. Some of the common causes of "sudden death" or injury that may require CPR include: suffocation, electric shock, cardiac arrest, severe allergic reaction, drowning and unintentional poisonings.

FOR THE FIRST TIME

- Advances in science, adult education and technology make it possible for people to learn CPR in their own homes and at their own pace.
- A new product, CPR Prompt, produced by County Line Limited and other companies, makes this possible.
- A community-wide effort makes it possible for anyone to learn CPR at no cost to the participant.
- Anyone with a library card and access to a VCR can learn CPR.
- The percent of the population with CPR skills could dramatically increase.

Poster

APRENDA REANIMACION CARDIOPULMONAR (RCP) EN SU CASA

DISPONIBLES EN LAS SIGUIENTES BIBLIOTECAS

CHERRYDALE, AURORA HILLS Y COLUMBIA PIKE

RESCATAME **APRENDA**

ADULTOS
NINOS
LACTANTES
OBSTRUCCION
DE LA VIA AEREA

DEPARTAMENTO DE BIBLIOTECAS

El programa de auto aprendizaje **RCP**
Patrocinado por la Asociacion Profesional de Bomberos y Paramedicos, el Departamento de Bibliotecas del Condado de Arlington y el Departamento de Bomberos del Condado de Arlington

PARA MAS INFORMACION LLAMAR AL:
228 - 4659

Brochure

RESCATAME

PROGRAMA DE CPR

APRENDA CPR

EN SU CASA
A SU CONVENIENCIA
SIN NINGUN COSTO

COMO?

VAYA A SU BIBLIOTECA PUBLICA
SOLICITE EL **PROGRAMA RESCATAME**
PRESTESELO Y LLEVESELO A SU CASA

QUE ES EL PROGRAMA RESCATEME?

ES UN PROGRAMA DE INSTRUCION .....
EL PROGRAMA CONTIENE UN VIDEO PASO A PASO, Y UN MANEQUIN DE PRACTICA
EL VIDEO LO GUIA ATRAVEZ DEL PROCESO DE CPR
HACE QUE APRENDER CPR SEA FACIL
TODO LO QUE USTED NECESITA ES UN VCR Y SU TARJETA DE LA BIBLIOTECA PUBLICA

RESCATAME

PROGRAMA DE CPR

QUE?

RESCATAME ES UN NUEVO E IMPORTANTE PROGRAMA DE SALVAVIDAS. ESTE PROGRAMA GRATIS LE DA LA OPORTUNIDAD DE APRENDER CPR EN SU PROPIO HOGAR SIN NINGUN COSTO.

POR QUE?

POR QUE SOLO EL 30 % DE LA POBLACION ES ENTRENADA EN CPR, A SIDO INTROUDICIDO UN NUEVO METODO QUE AYUDARA A QUE MAS GENTE PUEDA APRENDER CPR.

QUIEN?

RESCATAME ES PARA CUALQUIER PERSONA, ESPECIALMENTE SI USTED VIVE O TIENE PERONAS CON RIESGOS ALTOS; POR EJEMPLO ALGUIEN CON UNA HISTORIA DE PROBLEMAS CARDIACOS O RESPIRATORIOS. FAMILIAS CON NINOS PEQUENOS O ANCIANOS PUEDEN TAMBIEN ADQUIRIR TRANQUILIDAD MENTAL .

COMO?

CUALQUIER PERSONA CON UNA TARJETA DE LA BIBLIOTECA PUEDE PRESTARSE EL PROGRAMA DE LAS BIBLIOTECAS AURORA HILL, CHERRYDALE O COLUMBIA PIKE. TODO LO QUE NECESITA ES ACCESO A UN VCR PARA VER EL VIDEO PASO A PASO.

ESTATISTICAS ALARMANTES

1. MAS DEL 70 % DE LAS EMERGENCIAS CARDIACS CORURREN EN HOGARES CUANDO UN FAMILIAR ESTA PRESENTE.
2. MAS DE 1.5 MILLONES DE ATAQUES AL CORAZON OCURREN CADA ANO, Y APROXIMADAMENTE 250.000 DE ESTOS PERSONAS FALLECEN ANTES DE LLEGAR AL HOSPITAL.
3. MENOS DEL 7 % DE LA GENTE QUE SUFRE ARRESTO CARDIACO FUERA DEL HOSPITAL SOBREVIVE.
4. CUANDO LA RESPIRACION PARA, LA PERSONA PUEDE SOBREVIVIR POR SOLO 4 A 6 MINUTOS ANTES DE QUE LA FALTA DE OXIGENO EMPIECE A CAUSAR DANOS CEREBRAL O MUERTE. CPR AYUDA A PROLONGAR ESTE INTERMEDIO DE 4 A 6 MINUTOS CIRCULANDO ARTIFICIALMENTE SANGRE Y OXIGENO AL CEREBRO HASTA QUE LA AYUDA PROFESIONAL LLEGE.

5. ENTRE 100.00 Y 200.000 VIDAS PUDEN SER SALVADAS CADA ANO SI SE PERFORMA CPR A TIEMPO, DE ACUERDO A LA ASOCIACION AMERICANA DEL CORAZON.
6. CPR NO ES SOLO PARA ATAQUES DEL CORAZON. MAS DE 16 MILLONES DE NINOS TERMINAN EN EL HOSPITAL CADA ANO. ALGUNAS DE LAS CAUSA COMUNES DE MUERTE INSTANTANEA O UNA LESION QUE REQUIERE CPR INCLUYEN: AXFICCION, CHOQUE ELECTRICO, ARRESTO CARDIACO, REACCION ALERGICA SEVERA, AHOGO Y ENVENENAMIENTO SIN INTENCION.

POR PRIMERA VEZ

AVANCES EN LA CIENCIA, EDUCACION ADULTA Y TECNOLOGIA HACEN POSIBLE QUE PERSONAS PUEDAN APRENDER CPR EN SUS HOGARES Y A SU PROPIO RITMO.

UN NUEVO PRODUCTO, CPR PROMT FABRICADO POR COUNTY LINE LIMITED Y OTRAS COMPANIAS HACEN QUE ESTO SEA POSIBLE.

CON UN ESFUERZO DE LA COMUNIDAD SE HACE POSIBLE QUE CUALQUIER PERSONA PUEDA APRENDER CPR SIN NINGUN COSTO AL PATICIPANTE

CUALQUIER PERSONA CON TARJETA DE LA BIBLIOTECA Y ACCESO A UN VCR PUEDE APRENDER CPR.

EL PORCENTAJE DE PERSONAS CON CONOCIMIENTOS DE CPR PUEDE AUMENTAR DRAMATICAMENTE.

APPENDIX F

EVALUATION FORMS

Arlington County Fire Department

Rescue Me Survey

Please take just a minute and help us determine the usefulness of this community wide self-instruction program by answering the following questions.

1. Are you ☐ male or ☐ female

2. What age group are you? ☐ under 14 ☐ 14-20 ☐ 21-35 ☐ 36-50 ☐ 51+

3. Please check the parts that were completed: ☐ adult ☐ child ☐ infant

4. How many people viewed the tape or used the manikins? _____

5. How many times did you use the kit? _____

6. Did you find Rescue Me convenient to use? ☐ yes ☐ no

7. Would you check it out again? ☐ yes ☐ no

8. Have you ever taken a CPR class before? ☐ yes ☐ no

9. Do you plan to take a CPR class? ☐ yes ☐ no

10. Do you feel confident about your skill? ☐ yes ☐ no

11. How did you learn about it? ☐ newspaper ☐ flyer ☐ TV ☐ word of mouth ☐ other_____

Comments:_____

_____

Thank you for your time. Place this survey back inside the CPR kit.

DEPARTAMENTO DE BOMBEROS DEL CONDADO DE ARLINGTON

ENCUESTA "RESCATAME"

Por favor tome un minuto y responda a las siguientes preguntas, las cuales nos ayudaran a determinar la ulitidad de este programa de auto aprendizaje.

1.- Es usted hombre mujer

2.- A que grupo de edad pertenece? Menor de 14 anos 14-20
21-35 36-50 51 +

3.- Por favor marque las secciones que completo.
--- Adulto --- nino --- lactantes

4.- Cuantas personas vieron el video o usaron los manequis? ----

5.- Cuantas veces uso usted el equipo?

6.- Rescatame fue facil de usar? si no

7.- Lo usaria de nuevo? si no

8.- Tomo clases de reanimacion cardiopulmonar (RCP) antes ? si no

9.- Piensa tomar clases de RCP? si no

10.- Se siente seguro de su habilidad? si no

11.- Como se entero de este programa.
-- periodico -- poster -- TV -- por medio de otra persona --- otro

Observaciones:

_____

_____

_____